

NUFFIELD COUNCIL ON BIOETHICS

Response to the Cosmetic Practice Standards Authority draft clinical practice standards

October 2017

Introductory remarks

- 1 The Nuffield Council on Bioethics welcomes the CPSA's draft standards and, more broadly, its collaboration with the JCCP. However, as with other examples of good practice initiatives in the context of cosmetic procedures, we are concerned that for practitioners, registration with the JCCP, and meeting standards set out by the CPSA, are voluntary.
- 2 We recognise, however, that the establishment of the JCCP and CPSA marks the start of a process, and we hope that those who govern these two organisations will support any move to a mandated system for cosmetic procedures practice in the future.

Background

- 3 In June 2017, the Nuffield Council published a report of a two-year inquiry on *Cosmetic procedures: ethical issues*.¹ We draw on this report in commenting on aspects of the draft section on 'Overarching principles'.² We respond to the following sections:
 - Professionalism;
 - Supervision and accountability;
 - Patient journey; and
 - Fees and advertising.

Professionalism

Probity

"Practitioners must recognise vulnerable patients and guide them away from treatment if it is inappropriate".

- 4 When offering cosmetic procedures, practitioners have a professional responsibility towards those whom they treat. However, there may be a tension

¹ Nuffield Council on Bioethics (2017) *Cosmetic procedures: ethical issues*, available at: <http://nuffieldbioethics.org/project/cosmetic-procedures/>.

² CPSA (2017) *CPSA clinical practice standards: overarching principles*, available at: http://www.cosmeticstandards.org.uk/uploads/1/0/6/2/106271141/cpsa_overarching_principles_for_consultation_final.pdf.

between this responsibility and the commercial nature of the industry in which most cosmetic procedures take place (i.e., outside the NHS). We suggest that the CPSA standards, and in particular the statement highlighted above, might benefit from noting this tension. It may be harder than it seems for practitioners to “guide them away”, given economic pressures. The CPSA’s standards should recognise potential tensions and guide practitioners through managing such situations.

- 5 It may be equally difficult for practitioners to recognise vulnerable patients. We suggest that the CPSA draws on guidance such as that issued by the [GMC](#) for doctors who offer cosmetic interventions, which states that doctors must “consider patients’ psychological needs and whether referral to another experienced professional colleague is appropriate.” The point on referral is particularly important: if professionals guide potentially vulnerable users away from treatment, thought must be given to what happens to that vulnerable user next. Standards must take into account what happens when users are turned away (e.g., addressing the risk that they may instead go to a less scrupulous practitioner). Although the GMC standards are aimed at doctors, we feel that they may form a good starting point for this aspect of the CPSA’s standards, and warrant inclusion in the list of resources under the Professionalism / Probity part of this standard.

Efficacy of treatments

- 6 This subsection calls for “practitioners to be open and honest about the efficacy of treatments. If little or no evidence is available, practitioners must have a frank discussion around the procedure” and requires that practitioners “must provide effective treatments based on the best available evidence”. This section highlights a general issue of concern in the context of cosmetic procedures: that there is little evidence of efficacy, and what does exist is of poor quality (through low numbers of research participants, or short follow-up periods, for example). This lack of data therefore puts practitioners who try to adhere to this standard in a difficult position. In the Nuffield Council’s report, we recommend that the JCCP should work with the Royal College of Surgeons and the Private Healthcare Information Network to close gaps in data. If such a collaboration is embarked upon, it will make the terms set out in the CPSA standards more achievable for its subscribers.

Multidisciplinary team (MDT) working

- 7 We very much welcome this subsection of the standard, particularly the requirement that a MDT must be consulted prior to a cosmetic procedure being carried out on a child. MDT working will, we believe, further support practitioners in achieving the standard’s requirement that they recognise vulnerable patients: it is imperative that practitioners recognise the limits of their own competence, not only with respect to their skills in providing particular procedures, but also with reference to understanding the needs, experiences, and motivations that bring individuals to request those procedures. The fact that cosmetic procedures constitute a physical intervention whose hoped-for benefits are primarily psychological highlights the importance of practitioners, at the very least, having access to psychological expertise, through MDT working or other forms of

professional and peer support. We suggest, for clarity, that the standard includes an example of who might comprise a MDT.

Supervision and accountability

Provider accountability framework

- 8 This section calls for providers to demonstrate that “an accountability framework [is] in place, and recognised by all staff, knowing their line manager and how to escalate concerns”; and “a provider induction takes place for all employees – delivering corporate vision and strategy, organisational values and reinforcing ethical code of practice”. For some providers, however, practitioners are not employed directly, but instead are afforded practising privileges with sole responsibility for their own professional practice (see paragraphs 3.23, and 8.36-7 of the Nuffield Council’s report).³ We therefore suggest that the standard’s reference to ‘staff’ should be broadened out: for example, “staff, or those who carry out procedures on behalf of the provider”.

Patient journey

Patient consultation

Initial consultation

- 9 This section requires that initial consultations should adhere to the following requirements:
- Must be in person, face-to-face with an appropriately trained practitioner.
 - Must not be with an industry representative selling a product.
 - Should not be delegated to unqualified staff who are unable to perform the procedure and cannot carry out the consent process.
 - Practitioners may need to offer a second (and more if required) consultation prior to embarking upon treatment especially for more invasive procedures.

We agree with the CPSA’s stance here: we further note that sales staff should never be described as ‘advisors’, and should not offer advice (paragraph 8.51 of our report).⁴

History and examination

- 10 We suggest that the CPSA consider and reflect on the importance of obtaining information, where necessary, from users’ GPs. We suggest that the default position, given the potential for harm to health, should include the involvement of GPs in order to ensure that relevant medical information that could affect the outcome of the procedure is available. If users refuse to allow their GP to be contacted, practitioners should only proceed if confident that they have the background medical information they need (see paragraph 8.53, bullet 3).⁵

³ Nuffield Council on Bioethics (2017) *Cosmetic procedures: ethical issues*, available at: <http://nuffieldbioethics.org/project/cosmetic-procedures/>, at pages 50 and 158–9.

⁴ *Ibid.*, at page 163.

⁵ *Ibid.*, at page 164.

Follow up consultations

- 11 We welcome the focus on post-procedure follow-up in the draft standards. During the course of our own research, we were told that the degree of follow-up offered after a procedure, and what is or is not included in that follow-up, varies considerably across providers and practitioners.

Managing expectations

- 12 We support this section of the standard. We suggest further that addressing users' expectations of the procedure forms part of good practice in shared decision-making consultations between provider and user. For example, for a patient seeking lip fillers, the consultation would explore both the hoped-for physical change (such as fuller lips) and psychosocial changes (such as feeling less preoccupied with their lips, more confident, or more attractive). While practitioners can usually make a fair assessment of whether the user's wishes can be achieved physically, they cannot assess or guarantee that the physical change will bring the psychological changes the user is hoping for. Distinguishing clearly between the physical and psychological is likely to help patients make a realistic assessment of the procedure and to make a decision that is right for them. (See Box 8.2)⁶

Patient correspondence

“Cancellation policies should be clear to the patient before they embark upon treatment and before any payment is made. A full refund of treatment fees shall be given if any pre-payment is made when the cancellation is within the “cooling-off” period. Further arrangements are at the practitioner / clinics discretion but shall be clearly explained and set out in writing to patients.”

- 13 We suggest that the timing of fees and cooling-off periods are inherently linked to consent processes around cosmetic procedures. We take the view that shared decision-making should lead to a two-part consent process, including a cooling-off period. Users should not be asked to make financial commitment before the end of this process. It is meaningless to emphasise that users have the right to withdraw or change their mind at any point if, in practice, they have made substantial financial commitments at the first consultation.

Fees and advertising

Adverse events, incident reporting and evaluation of compliance

- 14 We note the standard's assertion that the JCCP will help to identify outcome trends related to procedures and products. Given the dearth of evidence around outcomes for cosmetic procedures, we suggest that this data be shared openly. It is also critical that adverse incidents are reported to the MHRA.

⁶ Ibid.

Conclusion

- 15 While the standards set out by the CPSA in this consultation are a positive contribution to improving the consistency and safety of cosmetic procedures in the UK, members of the public who wish to access cosmetic procedures must be made aware of these standards, and 'what they mean'. For the CPSA, and also for the JCCP, it is therefore imperative that an awareness exercise is undertaken so that members of the public can easily recognise the quality mark logo attached to those practitioners who meet the CPSA's standards.
- 16 Should additional information or clarification of our response to the draft standards be helpful, we would very much welcome the opportunity to discuss further.

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